

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0043513</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>COTTONWOOD HEALTH CARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>820 EAST 5TH ST, P.O. BOX 950</u> <u>GALESBURG</u> <u>61402</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>KNOX</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Larry Bonds</u> (Title) <u>President</u>																									
<b>Telephone Number:</b> <u>(309) 342-5135</u> <b>Fax #</b> <u>(309) 342-9974</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> <b>Fax #</b> ( )																									
<b>IDPA ID Number:</b> <u>830320180011</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>																									
<b>Date of Initial License for Current Owners:</b> <u>2/7/98</u>																											
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input checked="" type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>IRS Exemption Code</b> _____																											
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>William H. Keys</u> <b>Telephone Number:</b> <u>(317) 208-2740</u>																											

## STATE OF ILLINOIS

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Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>0</u>	Skilled (SNF)	<u>0</u>	<u>0</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>97</u>	Intermediate (ICF)	<u>97</u>	<u>35,405</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>0</u>	<u>0</u>	<u>0</u>		8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>30,266</u>	<u>215</u>	<u>0</u>	<u>30,481</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>30,266</u>	<u>215</u>		<u>30,481</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.09%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/7/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	166,754	15,736	5,076	187,566		187,566		187,566		1
2	Food Purchase		108,528		108,528		108,528	(95)	108,433		2
3	Housekeeping	125,744	7,895	90	133,729		133,729		133,729		3
4	Laundry	55,619	7,127		62,746		62,746		62,746		4
5	Heat and Other Utilities			43,760	43,760		43,760	356	44,116		5
6	Maintenance	38,113	5,353	12,145	55,611		55,611	15,895	71,506		6
7	Other (specify):*			5,420	5,420		5,420		5,420		7
8	<b>TOTAL General Services</b>	386,230	144,639	66,491	597,360		597,360	16,156	613,516		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	18,814			18,814		18,814		18,814		9
10	Nursing and Medical Records	1,134,824	23,946	14,640	1,173,410		1,173,410		1,173,410		10
10a	Therapy		4,034		4,034		4,034		4,034		10a
11	Activities	75,413	1,066	3,321	79,800		79,800		79,800		11
12	Social Services	57,359		2,868	60,227		60,227		60,227		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,286,410	29,046	20,829	1,336,285		1,336,285		1,336,285		16
	<b>C. General Administration</b>										
17	Administrative	58,701		2,829	61,530		61,530	1,815	63,345		17
18	Directors Fees										18
19	Professional Services			8,333	8,333		8,333	33,862	42,195		19
20	Dues, Fees, Subscriptions & Promotions			1,046	1,046		1,046	224	1,270		20
21	Clerical & General Office Expenses	52,541	37,581	122,452	212,574		212,574	58,333	270,907		21
22	Employee Benefits & Payroll Taxes			275,265	275,265		275,265	8,770	284,035		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,131	13,131		13,131	800	13,931		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			88,417	88,417		88,417		88,417		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	111,242	37,581	511,473	660,296		660,296	103,804	764,100		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,783,882	211,266	598,793	2,593,941		2,593,941	119,960	2,713,901		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

COTTONWOOD HEALTH CARE CENTER

#0043513

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			52,884	52,884		52,884	675	53,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			351,802	351,802		351,802	1,634	353,436			32
33	Real Estate Taxes			24,326	24,326		24,326		24,326			33
34	Rent-Facility & Grounds							4,453	4,453			34
35	Rent-Equipment & Vehicles			1,413	1,413		1,413	358	1,771			35
36	Other (specify):*							249	249			36
37	<b>TOTAL Ownership</b>			430,425	430,425		430,425	7,369	437,794			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			205	205		205		205			38
39	Ancillary Service Centers		241	839	1,080		1,080		1,080			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		241	54,152	54,393		54,393		54,393			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,783,882	211,507	1,083,370	3,078,759		3,078,759	127,329	3,206,088			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number COTTONWOOD HEALTH CARE CENTER

# 0043513

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(87)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,055)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,020)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)	(1,431)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,601)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	130,930	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 130,930		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 127,329		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS  
COTTONWOOD HEALTH CARE CENTER

Page 5A

ID# 0043513  
Report Period Beginning: 1/1/2002  
Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4	Non-Patient Meals	(87)	2	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13	Sales Tax	(8)	2	13
14				14
15				15
16				16
17				17
18	Fines and Penalties	(1,055)	21	18
19				19
20				20
21				21
22	Special Legal Fees & Legal Retainers	(1,020)	19	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31	Other non allowable expense	(899)	30	31
32	Vending revenue	(532)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,601)		49

## Summary A

# 0043513

**Report Period Beginning:**

**1/1/2002**

**Ending:**

12/31/2002

[illegible]

## Summary B

<b>Facility Name &amp; ID Number</b>	<b>COTTONWOOD HEALTH CARE CENTER</b>	<b>#</b>	<b>0043513</b>	<b>Report Period Beginning:</b>	<b>1/1/2002</b>	<b>Ending:</b>	<b>12/31/2002</b>
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**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



Facility Name &amp; ID Number COTTONWOOD HEALTH CARE CENTER

# 0043513

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$ 1
2	V	2 Food Purchase		Senior Living Properties, LLC	100.00%	0	2
3	V	3 Housekeeping		Senior Living Properties, LLC	100.00%	0	3
4	V	4 Laundry		Senior Living Properties, LLC	100.00%	0	4
5	V	5 Heat and Other Utilities		Senior Living Properties, LLC	100.00%	356	356 5
6	V	6 Maintenance		Senior Living Properties, LLC	100.00%	15,895	15,895 6
7	V	7 Waste Removal		Senior Living Properties, LLC	100.00%	0	7
8	V	10 Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0	8
9	V	10a Therapy		Senior Living Properties, LLC	100.00%	0	9
10	V	17 Administrative		Senior Living Properties, LLC	100.00%	1,815	1,815 10
11	V	19 Professional Services		Senior Living Properties, LLC	100.00%	34,882	34,882 11
12	V	20 Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	224	224 12
13	V	21 Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	59,920	59,920 13
14	Total		\$			\$ 113,092	\$ * 113,092 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 Employee Benefits & Payroll Taxes	\$	Senior Living Properties, LLC	100.00%	\$ 8,770	\$ 8,770	15
16	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	800	800	16
17	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	0		17
18	V	30 Depreciation		Senior Living Properties, LLC	100.00%	1,574	1,574	18
19	V	32 Interest		Senior Living Properties, LLC	100.00%	1,634	1,634	19
20	V	33 Real Estate Taxes		Senior Living Properties, LLC	100.00%	0		20
21	V	34 Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	4,453	4,453	21
22	V	35 Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	358	358	22
23	V	36 Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	249	249	23
24	V	0	0			0		24
25	V	0	0			0		25
26	V	0	0			0		26
27	V	0	0			0		27
28	V	0	0			0		28
29	V	0	0			0		29
30	V	0	0			0		30
31	V	0	0			0		31
32	V	0	0			0		32
33	V	0	0			0		33
34	V	0	0			0		34
35	V	0	0			0		35
36	V	0	0			0		36
37	V	0	0			0		37
38	V	0	0			0		38
39	Total		\$			\$ 17,838	\$ * 17,838	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER# 0043513Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTE # 0043513 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC  
 Street Address 12400 N. Meridian Street, Suite 180  
 City / State / Zip Code Carmel, Indiana 46032  
 Phone Number (317) 208-2740  
 Fax Number (317) 575-2562

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	See attachment	See attachment	See attachment	\$ 163	\$	See attachment	0	1
2	2 Food Purchase	See attachment	See attachment	See attachment	0		See attachment	0	2
3	3 Housekeeping	See attachment	See attachment	See attachment	0		See attachment	0	3
4	4 Laundry	See attachment	See attachment	See attachment	60		See attachment	0	4
5	5 Heat and Other Utilities	See attachment	See attachment	See attachment	18,884		See attachment	356	5
6	6 Maintenance	See attachment	See attachment	See attachment	741,985		See attachment	15,895	6
7	7 Waste Removal	See attachment	See attachment	See attachment	0		See attachment	0	7
8	10 Nursing & Medical Records	See attachment	See attachment	See attachment	300		See attachment	0	8
9	10a Therapy	See attachment	See attachment	See attachment	0		See attachment	0	9
10	17 Administrative	See attachment	See attachment	See attachment	84,798		See attachment	1,815	10
11	19 Professional Services	See attachment	See attachment	See attachment	1,775,423		See attachment	34,882	11
12	20 Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	76,549		See attachment	224	12
13	21 Clerical & General Office Expense	See attachment	See attachment	See attachment	3,248,251		See attachment	59,920	13
14	22 Employee Benefits & Payroll Tax	See attachment	See attachment	See attachment	228,203		See attachment	8,770	14
15	24 Travel and Seminar	See attachment	See attachment	See attachment	821,540		See attachment	800	15
16	26 Insurance - Prop Liab Malpractice	See attachment	See attachment	See attachment	0		See attachment	0	16
17	30 Depreciation	See attachment	See attachment	See attachment	73,575		See attachment	1,574	17
18	32 Interest	See attachment	See attachment	See attachment	145,409		See attachment	1,634	18
19	33 Real Estate Taxes	See attachment	See attachment	See attachment	16		See attachment	0	19
20	34 Rent-Facility & Grounds	See attachment	See attachment	See attachment	208,088		See attachment	4,453	20
21	35 Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	32,533		See attachment	358	21
22	36 Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	12,011		See attachment	249	22
23	0	0			0				23
24	0	0			0				24
25	TOTALS				\$ 7,467,788	\$		\$ 130,930	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
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B. Show the allocation of costs below. If necessary, please attach worksheets.

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25



Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER # 0043513 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	GMAC Comm Mort Corp		X	Acquisition	\$25,006.00	2/6/98	\$ 3,566,506	\$ 4,018,761	2/1/08	0.0681	\$ 279,724	1	
2	Complete Care Services		X	Acquisition	\$921.00	2/6/98	157,810	166,685	2/6/08	N/A - None	N/A - None	2	
3	Manager Note		X	Acquisition	\$921.00	2/6/98	157,810	166,685	2/6/08	N/A - None	N/A - None	3	
4												4	
5												5	
	Working Capital												
6	Line of Credit		X	Working Capital	None	2/6/98	Various		Demand	Prime + 2%	27,725	6	
7	Other Interest										45,987	7	
8												8	
9	TOTAL Facility Related				\$26,848.00		\$ 3,882,126	\$ 4,352,131			\$ 353,436	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,882,126	\$ 4,352,131			\$ 353,436	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **COTTONWOOD HEALTH CARE CENTER**# **0043513** Report Period Beginning: **1/1/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.	\$	24,326	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	24,326	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	24,326	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	24,326	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	32,470	8
	1998	33,099	9
	1999	21,902	10
	2000	20,558	11
	2001	24,326	12
<b>FOR OHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME COTTONWOOD HEALTH CARE CENTER COUNTY KNOX

FACILITY IDPH LICENSE NUMBER 0043513

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317) 581-9513

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>99-23-12-6022</u>	<u>See Attached</u>	\$ <u>25,080.10</u>	\$ <u>25,080.10</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>25,080.10</u>	\$ <u>25,080.10</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.



## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 20,321

B. General Construction Type:
 Exterior
 MASONRY
 Frame
 STEEL
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	165,092	1998	\$ 32,300	1
2					2
3	TOTALS	165,092		\$ 32,300	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97		1998	1970	\$ 846,074	\$ 28,202	30	\$ 28,202	\$	\$ 138,661	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Alum slider		1998		560	37	15	37		167	9
10	concrete		1998		722	36	20	36		156	10
11	pavilion material		1998		2,506	125	20	125		542	11
12	water heater		1998		3,795	380	10	380		1,709	12
13	signage		1998		464	46	10	46		212	13
14	land improvement (purchase price)		1998		13,478	899	15	899		4,419	14
15	install gas range		1999		3,147	315	10	315		1,259	15
16	2 fire doors		1999		1,031	52	20	52		194	16
17	exterior door		1999		1,634	163	10	163		612	17
18	thermostat for water heater		1999		572	57	10	57		214	18
19	repiped part of kitchen		1999		595	24	25	24		90	19
20	power control unit		1999		581	29	20	29		99	20
21	laundry room concrete slab		1999		1,210	61	20	61		187	21
22	5 sprinkler heads		1999		1,256	50	25	50		154	22
23	carpeting		1999		2,859	572	5	572		1,763	23
24	windows		2000		613	88	7	88		183	24
25	replaced plumbing		2000		3,564	509	7	509		1,230	25
26	freezer repairs		2000		1,014	145	7	145		411	26
27	water tank repair		2000		2,851	285	10	285		760	27
28	garbage disposer		2000		1,000	200	5	200		467	28
29	land improvement (purchase price)		1998		(13,478)	(899)	15	(899)		(4,419)	29
30	drapery & hardware		2001		940	94	10	94		133	30
31	building improvement		2001		3,975	159	25	159		159	31
32	hot water heater		2002		4,775	398	10	398		398	32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63	(DON'T ENTER BELOW THIS LINE)									63
64	Total (This Page)									64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)			\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 885,738	\$ 32,027		\$ 32,027	\$	\$ 149,760	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 130,157	\$ 19,870	\$ 19,870	\$	Various	\$ 77,481	71
72	Current Year Purchases	2,113	88	88		Various	88	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 132,270	\$ 19,958	\$ 19,958	\$		\$ 77,569	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport		2000	\$ 12,750	\$ 2,550	\$ 2,550	\$	5	\$ 3,400	76
77										77
78										78
79										79
80	TOTALS			\$ 12,750	\$ 2,550	\$ 2,550	\$		\$ 3,400	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,063,058	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,535	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,535	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 230,729	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,771 Description: Central Supply - 215, Dietary - 539, Laundry - 34, Administrative - 625, Home Office - 358

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2003 \$                     

13.                      /2004 \$                     

14.                      /2005 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$	0	\$ 0
2	Licensed Speech and Language Development Therapist		hrs		0	0	0				2
3	Licensed Recreational Therapist	10a, 3	hrs		0	0	4,034		4,034		3
4	Licensed Physical Therapist		hrs		0	0	0				4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$ 4,034		\$ 4,034		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 35,161	\$	1
2	Cash-Patient Deposits	3,465		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	317,238		3
4	Supply Inventory (priced at )	8,331		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 364,195	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,300		13
14	Buildings, at Historical Cost	886,329		14
15	Leasehold Improvements, at Historical Cost	13,942		15
16	Equipment, at Historical Cost	148,054		16
17	Accumulated Depreciation (book methods)	(231,747)		17
18	Deferred Charges	55,247		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(203,950)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 700,175	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,064,370	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 60,751	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,692		28
29	Short-Term Notes Payable	938,368		29
30	Accrued Salaries Payable	189,647		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,191		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Other accrued expenses	(29,143)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,208,506	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	4,263,791		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,263,791	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,472,297	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,407,927)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,064,370	\$	48

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,372,219)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Restatements of Prior Year to allow rollforward</b>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,372,219)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,045,772)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>PRIOR YR ADJ - DEPREC</b>	<b>10,064</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,035,708)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,407,927)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,799,396	1
2	Discounts and Allowances for all Levels	(767,028)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,032,368	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	87	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 87	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	Vending	532	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 532	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,032,987	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	597,360	31
32	Health Care	1,336,285	32
33	General Administration	660,296	33
<b>B. Capital Expense</b>			
34	Ownership	430,425	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,285	35
36	Provider Participation Fee	53,108	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,078,759	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,045,772)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,045,772)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **COTTONWOOD HEALTH CARE CENTER**# **0043513**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,813	2,006	\$ 49,334	\$ 24.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,943	9,761	141,942	14.54	3
4	Licensed Practical Nurses	15,671	17,176	273,634	15.93	4
5	Nurse Aides & Orderlies	53,824	60,462	655,285	10.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,503	1,704	20,560	12.07	9
10	Activity Assistants	5,788	6,402	54,853	8.57	10
11	Social Service Workers	3,516	3,806	57,359	15.07	11
12	Dietician	1,884	2,086	28,555	13.69	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,367	17,831	138,199	7.75	15
16	Dishwashers					16
17	Maintenance Workers	3,003	3,445	38,113	11.06	17
18	Housekeepers	13,856	15,349	125,744	8.19	18
19	Laundry	5,932	6,541	55,619	8.50	19
20	Administrator	1,868	2,006	58,701	29.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,009	4,463	52,541	11.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	903	1,021	18,814	18.43	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,077	1,274	14,629	11.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,957	155,333	\$ 1,783,882 *	\$ 11.48	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 4,530	1, 3	35
36	Medical Director		7,800	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	60	7,175	10, 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,820	11, 3	44
45	Social Service Consultant	48	2,612	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	276	\$ 24,936		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **COTTONWOOD HEALTH CARE CENTER**# **0043513**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description				Description			
Karhryn Langan	Admin.	0	\$ 58,701	Workers' Compensation Insurance	\$ 55,354			IDPH License Fee	\$		
				Unemployment Compensation Insurance	(5,085)			Advertising: Employee Recruitment		558	
				FICA Taxes	155,081			Health Care Worker Background Check			
				Employee Health Insurance	69,915			(Indicate # of checks performed <u>17</u> )			
				Employee Meals	0						
				Illinois Municipal Retirement Fund (IMRF)*	0			Dues & Subscriptions		488	
					0			Advertising & Public Relations			
					0						
					0						
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 58,701								
B. Administrative - Other				Home Office Allocation						224	
Description			Amount					Less: Public Relations Expense ( )			
Contract Svcs - Administrator			\$ 2,829					Non-allowable advertising			
								Yellow page advertising			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,829	TOTAL (agree to Schedule V, line 22, col.8)			\$ 284,035	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 1,270
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount		Description	Amount		
Legal Fees	Various	\$ 1,020		N/A				Out-of-State Travel	\$		
Patient Litigation	Various										
Payroll Processing	Various	65									
Accounting	Various	3,500						In-State Travel		11,826	
EDP Services	Various	3,748									
								Seminar Expense		1,306	
								Business Meals		(1)	
								Home Office Allocation		800	
								Entertainment Expense			
								(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL			\$ 13,931
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 8,333								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number COTTONWOOD HEALTH CARE CENTER

STATE OF ILLINOIS

# 0043513

Report Period Beginning:

1/1/2002

Ending:

Page 23

12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 160 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 53,108  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 87
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.